IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

October 7, 2002

Re: IRO Case # M2-02-0962-01

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IRO's, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Neurological Surgery. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the ___ reviewer who reviewed this case, based on the medical records provided, is as follows:

> History
> This case involves a 49-year-old female who in ___ was lifting file boxes and developed pain in her back which soon radiated into her lower extremities. The pain persisted despite rest and medication. An MRI 3/7/01 showed a disk rupture at L5-S1 with some chronic changes at L4-5 secondary to significant degenerative disk disease. Epidural steroid injections were not of significant benefit. On 8/16/01 a lumbar hemilaminectomy. with disk rupture removal at the L5-S1 level was performed. Ten weeks post op the patient's pain recurred without any significant re-injury. A repeat MRI 12/14/01 showed a small but definite disk rupture at L5-S1 once more, along with considerable scarring. Epidural steroid injections were of no help. The back and lower extremity pain continue.

Requested Service
Lumbar laminectomy at L5-S1 with discetomy and fusion

Decision
I disagree with the carrier's decision to deny the requested procedure.

Rationale
Findings on examination and MRI are appropriate as to the source of the patient's difficulty and the persistence of her pain. The good initial result following disk rupture removal would indicate that a repeat operation would be beneficial. It would be indicated to perform a fusion , with the disk rupture having recurred
It would also be appropriate to include the L4-5 level because in all medical probability disk difficulty requiring surgery may well occur at that level. If it is not included in the operative fusion.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d). A request for a hearing should be sent to:
Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P O Box 40669, Austin, TX 78704-0012. **A copy of this decision should be attached to the request.**

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308(t)(2)).

Sincerely,